KOHLER
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Putting the pieces together

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Welcome to our newest edition of Kohler HealthCare Consulting's "Pieces for Success". *We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.*

IN THIS ISSUE.....

ADDITIONAL INFORMATION 9

TIDBITS, ANNOUNCEMENTS AND EDUCATIONAL/SPEAKING ENGAGEMENTS

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us at 410-461-5116.

- **KHC White Papers -** (1) Telemedicine; (2) Proposed E/M Changes for 2019; (3) Hierarchical Codes - Contact Jessica Felder at jfelder@kohlerhc.com or 410-461-5116 to request a copy.

- **American Medical Association Launches a Tool for Suicide Detection.** Finding the patient who is at risk for violence or suicide is a challenging issue for physicians, covering domestic violence, depression, and for bullying. The tool concentrates on gun violence and includes training on counseling parents in pediatric setting about firearm safety. https://www.ama-assn.org/delivering-care/public-health/preventing-violence

- **A Few IRS Updates:** 2019 limit on 401(k), 403(b), and most 457 plans are $19,000, with the catch up contribution limit (for those over 50) remaining at $6,000.00. The Social Security Administration announced the maximum amount of wages subject to the social security tax goes up to $132,900 for 2019, up from $128,400, with the same rate at 6.2%. The Medicare tax remains at 1.45%

- **Learn About the Jayne Koskinas Ted Giovanis Foundation – Racing for the Benefit of Camp Boggy Creek and Healthcare Research.** Listen to Ted Giovanis' interview at the ROAR at Daytona International Speedway. It's the first listed podcast - the one that's 24 minutes. It's focus generally is on TGM (the race team), JKTGF and Camp Boggy Creek. It's actually less on TGM and more of JKTGF research and the work of Camp Boggy Creek. In it he talks about the work of the JKTGF, cancer, how research is funded, collaborations and why they are important in racing and science, among other things. https://itunes.apple.com/us/podcast/sports-car-unleashed-special-interview/id400013294?i=1000428349264&mt=2

- **Increased Use of Home Dialysis Projected.** Currently about 12% of dialysis is done at home, per US Renal Data Systems (USRDS) as of 2016. Even the major providers of dialysis are seeing the handwriting: *Modern Healthcare* (1/29/19) reported that both Fresenius and DaVita are expecting 25% of dialysis to be done at home by 2022, and 2025, respectively. For example, Fresenius is trying to buy NxStage a home dialysis device maker. That means that providers of dialysis are looking at a change in the 80% of the market they control – including their investment in facilities, staff and physician practices. However, the ordering physicians are then responsible for the patient's care – but the lack of training in dialysis may play

a role. CVS Health has made an announcement that it plans to expand home dialysis. The difference in cost of home dialysis is significant when considering the numbers of encounters required for dialysis. Prima Health Analytics, using Medicare cost reports calculated an average of $256 per single in-center hemodialysis treatment in 2017, compared to $215 for in-home. A comment in this article mentioned that the growth of telehealth allows for the remote communication that has been lacking to assure patient safety.

- **Opioids – Where Did They Come From?** The Egyptians noted the use of Opium, as well as the Sumerians and the Assyrians, thousands of years ago. Morphine was separated from Opium in the early 1800s. In 1898, Germany's Bayer Co., derived Heroin from Opium, and marketed this as being at least 10x as potent as morphine ***with none of the addicting properties.*** In 1995, the FDA approved OxyContin, and starting in 2000 the sale of the pain killers skyrocketed, and the deaths rose as well. During 2012-2017 the rate of prescriptions started to slow. See more at New York Spine & Wellness Center, Center for Disease Control and Prevention, International Neuromodulation Society.

- **Re-Admission Rates – Published in 2018 "America's Health Rankings Senior Report". https://www.americashealthrankings.org/learn/reports/2018-senior-report/findings-state-rankings.** This is a very interesting report, but even more interesting is that Maryland data is not included. Some of the highest states are: Florida 15.5%; Alabama 15.6%; Louisiana 15.3%; Missouri 15.3%; Tennessee 15.3%; West Virginia 15.7%; Vermont 15.5%; and Nevada 15.6%.

- **I-9 Form-*Employment Eligibility Verification Form* and Viewing Original Documents** - Don't forget to update your blank I-9 forms to the current 2019 version and review the guidance pages from the Department of Homeland Services, U.S. Citizenship and Immigration Services to ensure adherence to Employment Eligibility Verification. Compliance with Federal law requires [within three business days of starting employment] that employees personally present to the employer or an authorized representative documentation that establishes their identity and employment authorization. For more information, FAQ and the new form with the instructions accessible through a link on the top of the form itself, see: https://www.uscis.gov/i-9;https://www.uscis.gov/i-9-central/questions-and-answers; https://www.uscis.gov/i-9-central .

- ***Please follow KHC on Linked In*: https://www.linkedin.com/company/kohler-healthcare-consulting-inc**

- **HCPro Books Authored by KHC Staff:**

  Long Term Care From A to Z, Written by KHC Staff— published in December 2016. The book is now available for sale thru: https://hcmarketplace.com/long-term-care-billing. See website for more details.

  Hospital Billing From A to Z, written by KHC staff is a reference guide that covers Medicare requirements with ease of use for those involved in hospital billing. The book is available thru: http://hcmarketplace.com/hospital-billing-from-a-to-z?code=EB313813&utm_source=HCPro&utm_medium=email&utm_campaign=HBFAZ

  Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPro: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

ACA, CDC, CMS, OIG, MEDICARE and MEDICAID UPDATES

IF YOU HAVE A SNF WITH STAFFING ISSUES…..THE SURVEYS WILL BE DONE ON THE WEEKENDS AND HOLIDAYS – Charlotte Kohler

Based on a Memo from November 2018, a list of facilities with potential staffing issues is being provided to CMS regional offices and state survey agencies to support survey activities to evaluate sufficient staffing. CMS is using payroll-based journal (PBJ) data to determine which facilities have potential staffing issues. Part of the analysis revealed facilities with significantly low nurse staffing levels on weekends and facilities, with several days in a quarter without an RN onsite. Consequently, states will now be required to conduct at least 50% (formerly 10%) of the

required off-hour surveys on weekends for facilities on CMS' list. In addition, if surveyors confirm that compliance for 42 CFR 483.35(b)(1) (requirement for a facility to provide the services of an RN seven days a week, eight hours a day) isn't being met, the facility will be cited under deficiency F-727. Also note that updates to the PBJ Policy Manual were also made, including additional guidance for deducting meal times for specific shifts, and an added Q&A to the PBJ Policy FAQs that explains the rationale for meal break policy.

Resources available from CMS are: MDS Census Summary Report: Allows users to retrieve the daily MDS-based patient census (i.e., count of patients) for each day in a quarter; and, MDS Census Detail Report: Allows users to retrieve a list of the patients that the MDS-based census is comprised of on a given date or dates.

These reports use the same methodology CMS uses to calculate each facility's census, which is then used to calculate the number of staff hours per patient per day posted on NHC. More information on these reports can be found at https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-pbj-providers.

- Select Section 12 – Payroll Based Journal (PBJ) Reports from the right side in the blue box
- Find the specific report you would like to run and go to the page number cited
- Follow the steps to pull the report.

eMEDICARE - MEDICARE IN THE TECHNOLOGIC AGE – Julie Leonard

In October 2018 the Centers for Medicare and Medicaid announced eMedicare, a multi-year program that "will modernize the way beneficiaries get information about Medicare and create new ways to help them make the best decisions for themselves and their families."

Some of the eMedicare initiatives include:

- An improved coverage wizard to help beneficiaries compare options at a deeper level to decide if Original Medicare or Medicare Advantage is right for them;
- A stand alone, mobile optimized out of pocket cost calculator that will provide information on both overall costs and prescription drug costs;
- A simplified log in for the Medicare Plan Finder (https://www.medicare.gov/find-a-plan/questions/home.aspx) tool using their online account (instead of the current process of entering 5 pieces of information to authenticate);
- A webchat option, which will be available within the Medicare Plan Finder for some beneficiaries; and, New easy to use surveys available across Medicare.gov so beneficiaries can continue to tell us what they want.

❖ eMedicare includes a blog https://www.medicare.gov/blog/emedicare-another-step-to-strengthening-medicare
❖ eMedicare also includes downloadable App for smartphones https://www.cms.gov/sites/drupal/files/MGOV-hmpg-highres-press_1.png

eMedicare seeks to meet the beneficiary where they are and make Medicare accessible and easy to navigate. "As of 2016, about two-thirds of Medicare beneficiaries indicate they use the Internet daily or almost daily (65%)."

Technology is in every arena of healthcare; EHRs, Robotic surgeries, online insurance verification, electronic claims submission and electronic funds transfers, patient portals, electronic communication between providers and beneficiaries including remote services and telehealth.

❖ The entire press release from CMS can be read here: https://www.cms.gov/newsroom/press-releases/cms-announces-new-streamlined-user-experience-medicare-beneficiaries-0

FINANCIAL MANAGEMENT

IS YOUR NON-PROFIT ORGANIZATION ACCEPTING CRYPTOCURRENCY FOR CONTRIBUTIONS? - Charlotte L. Kohler

In the February 2019 issue of the Journal of Accountancy, there is a very informative article that discusses the considerations and issues faced by any non-profit in dealing with "cryptocurrency" – which is a virtual currency such as bitcoin, that is not controlled or financially underwritten by any government. For those who have not dealt with this "intangible property" or "commodity", there are many attributes to it that make it a difficult "asset" to measure and secure. For example, you can't put it in a bank. It lives on an electronic device (called "cold storage", an off-line

archive of private keys) that must be secured. That translates into “who will manage and safeguard it” and how”? If it’s on a secure drive (not attached to the internet), it’s again the question of who and how… and where. In some ways that may be the easy part of accepting cryptocurrency. A significant issue is what is it worth? How do you value it for financial statement purposes? Then, there is the issue – how do you spend it? Do you take the cryptocurrency directly or go through an intermediary? Do you select the intermediary or does the donor? Some of these issues have been dealt with in the handling of stocks and other securities and so, this is an added and difficult nuance. The authors of this article (Searing and MacLeod) do an exquisite job of taking the reader through the issues and the need to develop a formal policy before the question arises.

TECHNOLOGY CORNER

DO YOU STRUGGLE TO ACCESS AND ANALYZE YOUR DATA? KOHLER HEALTHCARE CONSULTING LAUNCHES KOHLER [HC} ANALYTICS PLATFORM TO SOLVE COMPLEX HEALTHCARE BIG DATA AND ANALYTICS – Josh Leventhal and Anthony Borgetti

Kohler HealthCare deepened its data and analytics capabilities with its launch of the Kohler [HC] Analytics Platform (KAP) in January of 2019.

KAP is a new, advanced, HIPAA compliant cloud-based analytics platform designed to enable clients to focus on managing their business by streamlining the data cleansing, aggregation, analysis, and visualization process. KAP enables our clients to:

1. Quickly ingest disparate data sets of any size;
2. Meaningfully aggregate, harmonize, unify and relate that data;
3. Analyze and report on that data; and,
4. Utilize dashboards and automation to access actionable insights.

KAP leverages the latest in Microsoft's Azure cloud-based technology to support scaling which meets the needs of the most complex algorithms and largest data sets.

KAP is supported by recent hires, Josh Leventhal and Anthony Borgetti, who bring over two decades of experience in analyzing healthcare data and healthcare IT. Josh and Anthony will be sharing their experiences in Kohler HealthCare's monthly newsletter, "KHC Pieces for Success". Look for the "Technology Corner".

Stuck on a data problem or technology problem and need a little guidance? Interested in exploring how KAP can help your organization? Drop us a line at jleventhal@kohlerhc.com / 312.933.2752 or aborgetti@kohlerhc.com / 219.427.7465, we'd love to dialogue with you.

Josh Leventhal is a Managing Director with Kohler HealthCare. He has over 15 years’ hands on experience in healthcare data and analytics solving problems for providers, payers and life science organizations. Josh started his career in management consulting analyzing data for the largest joint defense litigations in the country before using his skills and expertise at local startups to assist the Medicaid managed care organization and medical research industries. His experiences as a consultant, product manager and developer allow him to work effectively with both business and technology stakeholders.

Anthony Borgetti is an Associate Director with Kohler HealthCare. He has over 10 years’ experience in healthcare analytics and IT. Anthony began his career as a systems analyst and quickly moved up through the ranks of BI Developer, Integration Developer, and Product Owner. Anthony started analyzing data for a company that focused on predictive analytics and reporting for care management. He then worked with a large Chicago based payer. He ended up getting back into healthcare after a multi-year stint as a Solutions Architect for a Microsoft Gold Partner. He is Microsoft certified in Azure Big Data Analytic Solutions and has proven competency in SQL Server, IoT, Machine Learning, and Microsoft Power BI. Anthony spent many years developing cloud-applications, integrating disparate sources of data and using his experience in cutting-edge technologies to further the advancement of medium to large organizations across the country.

CODING CORNER

EVALUATION AND MANAGEMENT CODES TO WATCH AND AVOID IN 2019 – Dawn Homer

Assessment Codes to Avoid with E/M

The CPT book is giving new guidance advising that you should not report a range of health and behavior assessment codes (99401-99412) with an E/M service on the same day – these codes are **96150-96155** which are bundled together.

- 96150 – Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.
- 96151 – re-assessment
- 96152 – Health and behavior intervention, each 15 minutes, face-to-face; individual
- 96153 – group (2 or more patients)
- 96154 – family (with the patient present)
- 96155 – family (without the patient present)

Watch Codes Reported with Evaluation and Management

Three codes are under review by the AMA because they are billed with an E/M service at elevated rates. The codes listed below have been picked up as being billed along with an E/M code more than half of the time. Reporting codes on the same date as an E/M would require the use of *modifier 25 and your documentation has to undoubtedly show that two distinct services were warranted.*

- 29105 – (Application of long arm splint (shoulder to hand))
- 64455 – (Injections of anesthetic and/or steroid drug into nerve of foot)
- 20551 – (Injections of tendon attachment to bone)

CHRONIC CARE MANAGEMENT DOCUMENTATION AND CODING – Robin Stover

Chronic Care Management (CCM) refers to care coordination provided outside of the regular office visit, for patients with multiple chronic conditions. In 2015, Medicare began offering monthly reimbursements for these types of services. Non-complex CCM services, billed under CPT 99490, includes at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, and encompasses the following elements:

- Use of Certified EHR
- 24/7 Access & Continuity of Care
- Comprehensive Care Management
- Comprehensive Care Plan
- Management of Care Transitions
- Home- and Community-Based Care Coordination
- Enhanced Communication Opportunities

An initial face-to-face visit with the billing practitioner is required. This is not included in the CCM service and may be separately billed. The billing provider must obtain patient informed consent prior to providing or billing for CCM services.

Types of providers who may bill for CCM include physicians and non-physician providers (PA, NP, CNM, CNS). Only one provider may bill CCM for a patient each month.

CPT Code Descriptions:

99490 - Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

99491 - Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored

Documentation Requirements:

- Document that appropriate clinical staff spent at least 20 minutes of non-face-to-face time providing CCM services within a given month.
- Record the date, time spent, name of provider, and the services provided.
- Include the diagnosis codes for the patient's chronic conditions.
- Document the time spent in total minutes and do not round up.
- Comprehensive Care Plan to include: summary of physical, mental, psychosocial, functional and environmental assessments; medication reconciliation; inventory of clinicians, resources and support specific to the patient including coordination of care if outside the practice; and assurance of care specific to patient's choices

OTHER ARTICLES OF INTEREST

FIGURES DON'T LIE: CANCER RATES CONTINUE TO DECLINE AND THERE IS MORE WORK STILL AHEAD - Susan Santoro

Cancer is the leading cause of death worldwide and the second leading cause of death in the United States. Despite this fact, there is good news for the United States. According to a recent American Cancer Society report[1], cancer death rates from 1991 – 2016 has dropped 27% primarily attributable to advancements in early detection and lifestyle changes.

"A decline in consumption of cigarettes is credited with being the most important factor for the drop in cancer death rates. Strikingly though, tobacco remains by far the leading cause of cancer deaths today, responsible for nearly 3 in 10 cancer deaths."[2]

The most common forms of cancer in men is prostate, lung and colorectal cancers. Breast, lung and colorectal cancers are the most common types in women. It is estimated that in 2019, approximately 606,880 Americans will die from cancer - almost 1,700 deaths per day.[3]

Cancer Incidence in Men and Women: Over the period of the study, cancer incidence rates for men declined 2% per year primarily due to the sharp decline in prostate cancer. This decline can be attributable to decreases in prostate screening testing based on recommendations from the U.S. Preventive Service Task Force.

For women, the cancer incidence rate has remained relatively constant. Noted were declines in lung cancer and colorectal cancers. Breast cancer, however, showed increased incidence rates particularly in Non-Hispanic White,

[1] Siegel RL, Miller KD, Jemal A, Cancer Statistics, 2019, CA Cancer J Clin 2019, 69:7-34, 2019 American Cancer Society.
[2] Facts & Figures 2018: Rate of Deaths from Cancer Continues to Decline, https://www.cancer.org/latest-news/facts-and-figures-2018-rate-of-deaths-from-cancer-continues-decline.html.
[3] Op.Cit., Siegel, Page 7.

Black (Non-Hispanic), American Indian/Alaskan Native and Asian Pacific Islander women. This trend may be partially attributable to obesity.

Cancer Mortality: A better measurement of the status of cancer care advancement is the cancer mortality rate. Since its peak in 1991, which was primarily due to lung cancer related to tobacco usage in men, the cancer death rate has declined 1.5% annually. This decline represents an aversion of 2.6 million cancer deaths.

Disparity in Cancer Rates: The report cited that based on lower socioeconomic status, in the 25 – 74-year old age cohort, approximately 34% of these disparities could be averted with the mitigation the socioeconomic factors. This is particularly noted in cervical cancer mortality rates in poorer countries which are two times higher than that of affluent countries.

Cancer in Children: Accounting for 28% of cases, leukemia is the most common form of cancer in children in the 1-14 age cohort. Although there has been a slight increase in cancer incidence rates, there has been a sharp decline in the cancer death rate – a dramatic overall 65% reduction (1970-2016) primarily driven by a 78% reduction in leukemia mortality.

Special Populations and Cancer

Cancer in The Oldest Old[4]: Commonly referred to as the Oldest Old, this adult age group 85+, is the fast-growing group in the US population expected to triple to 19.0 million from 6.4 million by 2060. For men and women, cancer risk peaks at age 80, and given longevity, there will be an increasing demand for cancer care. A cancer diagnosis risk for this age group is 1-in-6 for men (16.4%) or 1-in-8 for women (12.8%). Early stage cancer diagnosis is unlikely in the 85+ age group.

At ages 85+, cancer treatment is complicated due to other medical conditions and these patients are less likely to receive surgical care. This special section report found curative treatment, is less likely for patients with co-morbidities due to concerns with treatment side effects that include drug interactions and an exacerbation of coexisting conditions.

Young Adults and Obesity-Related Cancer: A recently published study analyzed invasive cancer data from 1995 – 2014 for 25 state registries for young adults in the 25-49 age cohort.[5] During this period, there were 1.4 million cases for 30 types of cancer. For six of the 12 obesity -related cancers, (multiple myeloma, colorectal, uterine corpus, gallbladder, kidney, and pancreatic cancer), the incidence increased significantly and even higher rises in the successive younger generations.

USA overweight or obesity prevalence in the USA between 1980- and 2014, increased more than 100% (from 14·7% to 33·4%) among children and adolescents and by 60% among adults aged 20–74 years (from 48·5% to 78·2%).

The alarming side of the obesity crisis is that obesity-related cancers could increase to the extent that the progress achieved thus far in cancer care could result in a backward trend in cancer incidence and mortality.

Conclusion

Although significant progress has been made in cancer early detection and treatment that resulted in lower incidence and mortality rates in some types of cancer, there is much more work still ahead. Equally important is cancer research in a society whose population must make the required lifestyle changes to continue to show positive results in the fight against cancer.

DIGITAL PRESCRIPTION PRIOR AUTHORIZATION – Sara Rivenburgh

Prior authorization (PA) is a requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you. PA is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance company. Generally, a standard request for authorization can take up to 15 days. If an urgent request is filed by the patient and their physician, a decision can be made within 24 hours. The insurance companies assert that this process protects patients from harmful drug interactions and side effects. However, research has shown that more than one third of prescriptions that require PA are abandoned by the patients. Lack of convenience and the complexity of the process exacerbates patient compliance. According to

[4] Cancer Fact & Figures 2019, Special Section Cancer in the Oldest Old, American Cancer Society, Page 29.

[5] Sung H, Siegel RL, Jemal A. Emerging Cancer Trends Among Young Adults in the USA: Analysis Of A Population-Based Cancer Registry, Lancet Public Health, February 4, 2019 published online.

an American Medical Association survey, 92% of physicians state that the bottle-neck of the PA process harms clinical outcomes.

In order to expedite the prior authorization process, many companies are offering an electronic alternative that can be integrated into existing electronic health record workflows. At their best, these tools can cut the PA process time to less than one minute. If the doctor has real-time benefit information at the point of care, they can opt for medications that don't require PA. This accomplishes the goals of boosting efficiency and saving money.

As with most developing electronic procedures, up-to-date information is the key to success. If the patient and payer information is outdated, it could trigger a PA when one isn't actually necessary. There is also the potential for manipulation by the pharmaceutical reps and pharmacies who could utilize the process to boost revenue.

OBTAINING YOUR MEDICAL RECORDS CAN STILL BE DIFFICULT – Diane Jordan

A new study performed by the Yale School of Medicine has found that patients are still facing difficulty in obtaining their medical records although HIPAA has been around for more than two decades. Federal law says patients must be given access to their medical records in a timely manner, in their preferred format, and at a reasonable cost. The Yale researchers found many hospitals make the process too confusing or expensive.

The study published in October in JAMA Network Open evaluated the medical records departments at 83 top-ranked U.S. hospitals in 29 states.

"There were overwhelming inconsistencies in information relayed to patients regarding the personal health information they are allowed to request, as well as the formats and costs of release, both within institutions and across institutions," says Carolyn Lye, the study's first author and a student at the Yale School of Medicine. "We also found considerable noncompliance with state and federal regulations and recommendations with respect to the costs and processing times."

On their record request forms, only 53% of the hospitals gave patients an option to access their full medical record. However, when asked over the telephone, all 83 hospitals said they could release full medical records to patients. There were also discrepancies between request forms and phone information about formats in which medical records could be released (electronic, paper, or in person).

The researchers also found that 58% of the hospitals charged more than the federally recommended $6.50 for medical records stored electronically. One hospital charged $541.50 for a 200-page record.

Only 35% of the hospitals disclosed the exact costs of accessing information on the authorization forms or on the page where the form could be downloaded. However, 22% stated that there was a cost but did not specify, and 43% didn't specify any fees at all. Only one (1) hospital released records for free.

Most hospitals released records in electronic format faster than paper format with the time of release for paper formats ranging from the same day to 60 days. In addition, the analysis found seven (7) hospitals had time ranges that went beyond their state's requirement.

The findings showed that since each institution creates unique processes, there was variability in what records could be requested and how records could be received. The researchers noted that the "lack of a uniform procedure" to request medical records in the United States "highlights a systemic problem in complying with the right of access under HIPAA."

The authors noted that since the study only included highly ranked hospitals, the results may not be representative of the process of requesting medical records at all hospitals in the United States.

Reference

Lye CT, Forman HP, Gao R, et al. Assessment of US Hospital Compliance With regulations for Patients' Requests for Medical Records. *JAMA Network Open.* 2018;1(6):e183014. doi:10.1001/jamanetworkopen.2018.3014

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2705850

ADDITIONAL INFORMATION

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